Premium Assistance

Richard E. Curtis and Edward Neuschler

Many low-income, uninsured children have access to employer coverage but are not enrolled, presumably because their parents cannot afford to enroll them. One strategy for increasing the enrollment of low-income children is to help parents pay the employee contribution required for family enrollment in their employment-based health insurance. This strategy is known as "premium assistance."

Premium assistance offers many potential benefits as a means for providing coverage to low-income children; but at the same time, several practical difficulties in realizing that potential remain.

Premium-Assistance Strategies Hold Promise for Many Children

Premium assistance is a promising strategy for providing coverage to children in low-income families with access to employer-provided coverage. As shown in Table 1, an estimated 55% of uninsured children in families with incomes between 133% and 200% of the federal poverty level (FPL) have access to employer coverage. Furthermore, public health insurance programs for children already authorize this type of assistance[1] and can help any eligible persons pay the premiums required to enroll in any private health insurance that is available to them. This approach is particularly cost effective for employment-based insurance because employers already pay a sizable share of the total premium. Overall, as this section details, premium assistance has the potential to cover more children with available public dollars, provide coverage to whole families, and help prevent "crowd-out" (that is, replacing or substituting for existing employer coverage) by complementing rather than replacing employer contributions.

Richard E. Curtis, M.P.P., is president of the Institute for Health Policy Solutions.

Edward Neuschler, M.P.P., is a senior program officer at the Institute for Health Policy Solutions.

Making Public Dollars Go Farther

Because employers typically pay about 70% to 75% of the cost of family coverage,[2] subsidizing workers' share of premiums to enroll their children as well as themselves in employer coverage can be less expensive than providing direct coverage, especially family coverage, under the State Children's Health Insurance Program (SCHIP) or Medicaid. For example, Rhode Island saves an average of $178 per month for every family enrolled in its RIte Share premium-assistance program rather than in its regular RIte Care (Medicaid and SCHIP) managed care program.[3]

Providing Coverage for Children and Families

Providing whole family coverage, either directly or through premium assistance, also benefits children by making it more likely that they will get needed care. Studies show that children are more likely to use care if their parents do, an effect that is even stronger if both parent and child are insured.[4] For example, in states that have expanded coverage for parents under Medicaid, 81% of eligible children participate in Medicaid, compared to only 57% of children in states without family-based coverage programs.[5] Moreover, states such as Wisconsin, Rhode Island, and New Jersey have

Table 1

Children with Employer Coverage and Uninsured, by Family Income Relative to Poverty

Family Income Relative to Federal Poverty Level	Among Children, Percent with Employer Coverage, 1999[a]	Among Children, Percent Uninsured, 1999[a]	Ratio of Children with Employer Coverage to Uninsured Children, 1999[a]	Percent of Uninsured Children Eligible for Employer Coverage through a Parent, December 1996[b]
Less than 100%	17.8%	27.1%	0.7:1	23%
100%–132%	41.4%	20.6%	2.0:1	40%
133%–199%	58.4%	19.7%	3.0:1	55%
200%–249%	72.7%	13.3%	5.0:1	62%
250%–399%	84.4%	8.0%	10.5:1	51%
400% and over	90.8%	4.5%	20.0:1	28%

[a] March 2000 Current Population Survey.
[b] 1996 Medical Expenditure Panel Survey (full-year panel).

Source: Institute for Health Policy Solutions

demonstrated that offering health insurance coverage for whole families is a more effective way to reach uninsured children than covering only children under SCHIP. For example, the number of children enrolled in Rhode Island's RIte Care program grew only 10% between December 1995 and December 1998. After coverage was expanded to parents (in November 1998), the number of children enrolled grew 47% over the next three years (ending in December 2001).[6]

Overall, because employer contributions for family coverage can greatly reduce the net cost of public subsidies needed, and because coverage through work is an attractive coverage venue for many working parents, subsidizing enrollment in employment-based family coverage can be a cost-effective way for states to provide coverage to entire low-income families.

Helping Prevent "Crowd-Out"

Using public dollars to offer premium assistance to low-income working families could cover more families at lower cost by complementing rather than replacing employer contributions. While greatly beneficial, public-program expansions that include parents as well as children may pose a greater risk of "crowding out" existing employer coverage when eligibility is extended above the FPL. Crowd-out is more likely above the FPL because private employment-based coverage is widespread among non-poor but low-income working families. For example, in families with incomes between 133% and 200% of the FPL, three times as many children had employer coverage as were uninsured in 1999 (see Table 1).[7]

Recent research indicates that a significant share of new public coverage for adults above the FPL replaces private (employment-based) coverage.[8] These findings suggest that virtually free public coverage induces many low- and modest-income families (and/or their employers) to drop existing employer coverage, which costs an average of almost $8,000 annually in combined employee and employer contributions. For example, after Rhode Island achieved the lowest reported rate of uninsured children in the country (2.4% in 2000),[9] the state's RIte Care program identified a significant shift from employer coverage (see Box 1).[10]

Because of their desire to stretch public funds by capturing available employer contributions, avoiding crowd-out and covering whole families where possible, state and federal officials remain keenly interested in programs that would help low-income families enroll their children in private employment-based insurance when it is available to them.

Challenges to Implementing Premium Assistance

Despite the substantial potential suggested by these data and observations, premium-assistance programs undertaken to date have reached relatively few children in 12 states.[11] The early experience of one of those states, Wisconsin, illustrates both the potential reach of

Box 1

Rhode Island Grapples with "Crowd-Out"

Rhode Island's RIte Care (Medicaid and SCHIP) program initially covered children up to 250% of the FPL. In late 1998, the state expanded the program to include coverage of parents up to 185% of the FPL. This expansion succeeded in covering more children as well as parents. By 2000, the program had reduced the percentage of children without insurance to 2.4% and the overall uninsured rate to 6.2%, the lowest rates in the nation.[a] Total RIte Care enrollment increased by 40% between November 1998 and June 2000, straining the state's budget.[b]

One reason for the explosive program growth was a shifting of low-income families out of employer coverage and into RIte Care, a process known as "crowd-out." The *Providence Journal* reported in May 2000 that as many as 20,000 people—almost 20% of the total program enrollment—may have dropped private health insurance in order to take advantage of the free state program.[c] The largest participating HMO, Neighborhood Health Plan, estimated that one-third of its new RIte Care patients were migrating from private insurance plans.[c] Another carrier experienced 4,200 voluntary disenrollments from its commercial coverage during 1999 that resulted in subsequent enrollment in the same carrier's RIte Care plan, 83% of them within four months after the commercial disenrollment.[d]

To address the problem of crowd-out, in June 2000, Rhode Island enacted a package of reforms that included an aggressive premium-assistance initiative (RIte Share) aimed at placing eligible families into employer coverage. The reforms included a review of the entire RIte Care caseload to identify families who had access to qualifying employer coverage and to enroll them in it, when it was cost effective for the state to do so. As of July 2002, about 2,200 members had been enrolled in RIte Share, with enrollment expected to reach 5,000 by June 30, 2003.[e]

While generally pleased with the program's success, state managers note that shifting costs back to the employer sector is more difficult than avoiding crowd-out in the first place, and they urge other states to initiate premium-assistance policies before expanding public health insurance programs, especially where parents will be covered in addition to their children.[b]

[a] Rhode Island Department of Human Services. Update: RIte Care, member cost sharing, RIte Share. Providence, RI: Hearing of the Joint Committee on Health Care Oversight, April 29, 2002. Slide presentation. Based on Medicaid Research and Evaluation Project; RIte Share Evaluation Studies. U.S. Bureau of the Census, Current Population Surveys 1994–2000 (September estimates).

[b] RIte Care enrollment increased from 74,221 in November 1998 to 104,041 in June 2000. Ferguson, C. Hindsight and foresight: Lessons for getting it RIte. In *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage.* Washington, DC: Institute for Health Policy Solutions, May 18, 2001.

[c] Rowland, C. Officials rethinking RIte Care's mission. *Providence Journal.* May 21, 2000, at p. A-01.

[d] Ferretti, S. Hindsight and foresight: Lessons for getting it RIte. In *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage.* Washington, DC: Institute for Health Policy Solutions, May 18, 2001.

[e] Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RIte Share program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation. Also, personal communication with P. Leddy, February 12, 2003.

Box 2

Wisconsin Experiences Both the Promise and Pitfalls of Premium Assistance

Wisconsin's attempt to integrate premium assistance into its SCHIP program, known as BadgerCare, illustrates both the potential reach of premium assistance in a low-income working population and the practical difficulties involved in realizing that potential. BadgerCare covers parents as well as children, but requires that families take advantage of employment-based coverage if it is available to them and cost effective. Roughly half of working BadgerCare applicants have access to health coverage through their employers. But, as of June 30, 2001, less than one-tenth of 1% had actually been enrolled.[a]

There are several reasons for Wisconsin's low rate of enrollment in employer-based coverage. The state's premium-assistance policies—some driven by federal requirements, some chosen by the state—unnecessarily exclude many employer plans from participation. For example, almost one-half of the applicants with access to employer coverage work for self-insured employers,[a] but the state initially decided to exclude self-insured plans from premium assistance in order to simplify and speed program implementation. (State officials have now reversed that decision.)

In addition, when the program first began, only employers who contributed between 60% and 79% of the cost of family coverage qualified, and only 20% of otherwise-qualified employer plans fell in that range.[a] The minimum required employer contribution has now been lowered to 40%.[b]

Wisconsin has also had difficulty getting the necessary information from employers. About 25% to 30% of forms requesting information are never returned, and of those that are, about one-quarter state that the applicant no longer works for that employer (or never did).[a] These problems have significant implications for verifying employment and earnings for the underlying BadgerCare program, not just for its premium-assistance component.

The initial structure of Wisconsin's program discouraged participation in several ways. As Wisconsin wrestles with fiscal problems, it is moving to address some of the key obstacles—for example, by including more employer plans and proposing to require information about their availability at application. With such changes, the potential of premium assistance is more likely to be realized.

[a] Wisconsin Division of Health Care Financing. Unpublished "employer verification of insurance coverage (EVIC)" program statistics obtained from Donald G. Schneider, Chief, Coordination of Benefits Section, July 27, 2001.
[b] Wisconsin Division of Health Care Financing. Personal communication with Donald G. Schneider, Chief, Coordination of Benefits Section, December 20, 2001.

premium assistance in a low-income working population and the practical difficulties involved in realizing that potential (see Box 2).

The next section describes some of the challenges facing states that seek to implement premium-assistance programs, including administrative costs and resource requirements, the difficulty of arranging "wrap-around" coverage, conflicting program policies, and questions of cost-effectiveness.

Administrative Costs and Resource Requirements

Identifying applicants with access to employer coverage and obtaining the information necessary to evaluate that coverage in a timely fashion can involve considerable effort and resources. The state of Iowa, for example, employs 14 full-time staff members to follow up on Medicaid clients identified by local offices as having access to employer coverage.[12]

States must do much of the necessary administrative work because employers do not want to be burdened with modifications to their existing health plan, payroll deduction, and related programs. And neither employers nor their workers want employers involved in ways that would make them privy to family income information. Employers' resistance to playing any administrative role increases when they realize it would increase their benefit costs while typically providing financial assistance and extra benefit coverage only to those workers who

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decline to contribute to coverage for their children. Workers who earn the same or less, and sacrifice financially to cover their children, would not benefit.

Difficulty of Arranging "Wraparound" Coverage

Employer-provided health plans generally do not cover every service available under Medicaid or SCHIP and often charge higher co-payments than Medicaid or SCHIP allows. Arranging wraparound or supplemental coverage to fill in these "gaps" in employer coverage is one of the biggest difficulties states face in pursuing premium-assistance programs under SCHIP.

Under Medicaid, a relatively simple solution to this problem already exists. Premium-assistance enrollees can use a traditional Medicaid card to access services not covered by their employer plans and also to avoid co-payments in excess of the Medicaid-allowable level. Several states that use this model, including Wisconsin and Iowa, have found that costs tend to be nominal, as most enrollees prefer to simply use their "mainstream" employer benefits.

Separate (non-Medicaid) SCHIP programs, however, generally do not have their own fee-for-service payment capability, which makes this approach to wraparound coverage unavailable to them.[13] Setting up or contracting for a separate claims-payment system solely to provide wraparound coverage for premium-assistance recipients would be prohibitively expensive,[14] and private health plans have not been willing to undertake the responsibility of "filling in" employer-plan coverage, which can vary widely, on an at-risk basis. Contracting with the state's Medicaid program or fiscal agent to provide wraparound coverage for SCHIP premium-assistance recipients is a possible alternative that only one separate SCHIP program—Virginia—has yet used.[15]

Conflicting Policies

While administrative difficulties are an important impediment, conflicting public-program policies—driven by inconsistent federal regulations and confusion about market roles and incentives—have also made it far more difficult to adopt and implement effective state programs.

Inconsistent Federal Regulations

Medicaid and SCHIP represent somewhat different public policy approaches to increasing children's coverage. The resulting differences in federal regulatory requirements between these two programs often preclude states from operating a single, integrated premium-assistance program (see Table 2). Instead, the two programs require inconsistent policies and, in effect, inconsistent communications to employers and working parents. For example, Iowa, which operates a large health-insurance-premium payment program under Medicaid, does not attempt such a program under SCHIP, even though, given the higher incomes involved, a much higher percentage of SCHIP children are likely to be eligible for employer coverage (see Table 1). Similarly, Maryland has attempted, albeit with minimal success to date, a premium-assistance initiative only for children between 200% and 300% of the FPL (eligible for its separate SCHIP program), and not for lower-income children under its much larger Medicaid or Medicaid-model SCHIP programs.[16]

In the world of employer coverage, such a fragmented approach makes no sense. Narrow income-eligibility ranges may make only a very small fraction of workers eligible for premium assistance for themselves and their children and could mean that higher-income workers qualify for premium assistance while lower-income workers in the same firm do not. Such a program would seem disjointed and unfair to parents whose larger family size lowers their income relative to poverty and thereby precludes them from receiving assistance for an employer family plan covering their colleagues. A less fragmented approach that incorporates a broader income range for premium assistance (incorporating both SCHIP and Medicaid income ranges) would be more equitable and broaden the eligible population considerably. (See the article by Blumberg in this journal issue for a discussion of the equity issues involved with designing programs narrowly versus broadly.) Almost three-quarters (73%) of uninsured children with access to employer coverage are in families with incomes below

250% of the FPL, but only one in eight (12.6%) are in the income range from 200% to 249% of the FPL.[17]

Confusing Market Roles and Incentives

Whether or not a worker has access to employer coverage is determined more by the worker's individual wage or salary level than by the family's total income relative to the FPL. Low-wage workers rarely have coverage from their employers, while higher-wage workers are very likely to have employer coverage, even if they are part of a low-income family. For full-time workers with family incomes between 133% and 200% of the

Table 2

Standards Related to Premium Assistance for Employer Coverage under Medicaid and SCHIP

Issue	Medicaid Health Insurance Premium Payment (HIPP)	SCHIP Premium Assistance (PA)	Waiver Possibilities under New Federal Guidance (HIFA)[a]
Are applicants eligible for premium assistance if they already have employer coverage?	Yes.	No. For SCHIP, applicants must be uninsured. For SCHIP premium assistance, applicants must have been without employer coverage for six months.	States could ask to use federal matching funds to subsidize some applicants who are already insured (within budget limits).
What is the minimum employer contribution required to qualify for premium assistance?	None.	State must specify one. No minimum percentage is specified in federal regulations, but in practice the federal government seems to require no less than 30%–40%.	Federal requirement to specify some minimum can be waived.
Must states provide supplemental coverage for services not covered by the employer plan?	Yes. Recipient must have access to all Medicaid-covered services. (Recipient can use traditional Medicaid fee-for-service card.)	Yes, unless the employer plan meets one of the SCHIP benchmarks. (Harder to handle. Most SCHIP programs have no fee-for-service claims-payment capability.)	Waiver guidance allows greater flexibility on benefit requirements for "optional" groups, so supplemental coverage is less likely to be needed.
Must states "fill in" employer-plan cost-sharing amounts that exceed program rules?	Yes. Essentially, no cost sharing is allowed for Medicaid recipients.	Yes. Must meet statutory SCHIP limitations prohibiting any cost sharing for well-child care and limiting other cost sharing to 5% of family income.	Allows greater flexibility. Only the 5-percent-of-income limit on cost sharing for children remains.
Must premium assistance be cost effective (that is, cost less than direct public coverage)?	Yes. (Most states use HIPP only for obviously high-cost cases. A few, such as Iowa, screen all recipients with access to employer coverage.)	Yes. Costs can be compared on a case-by-case basis or on an aggregate basis for the total premium-assistance population.	Requirement is less strict. Aggregate costs for all those covered under premium assistance must not be "significantly higher" than they would be under a public program.

[a] HIFA refers to the Health Insurance Flexibility and Accountability Demonstration Initiative, announced by the federal Centers for Medicare and Medicaid Services in August 2001.

Source: Based on federal rules and regulations governing Medicaid, HIPP, and SCHIP premium-assistance programs (last updated June 25, 2001), and the new HIFA waiver guidance.

FPL, for example, only 48% of those earning less than $15,000 per year have employer coverage, compared with 83% of those earning between $30,000 and $40,000 per year.[18]

These data suggest that states should consider individual parents' earnings in addition to total family income in designing public-program policies, particularly for programs that cover parents in addition to children. Basing contribution requirements for parents' coverage at least in part on individual earnings, for example, could help prevent crowd-out.[19] A parent's wage level might also be used as a screening tool to identify children who are more likely to have employer coverage available to them and, therefore, to be candidates for premium assistance.

Difficulty in Achieving Cost-Effectiveness if Only Children Are Eligible

Many states extend coverage above poverty only for children, not their parents. For these states, premium assistance is less likely to be a cost-effective alternative to direct public coverage, particularly when both the per-child public-program cost and employer contributions toward family coverage are relatively low.[20] To date, states have authorized premium assistance only when the family's cost to enroll in its employer's plan is less than the state's cost to enroll the children and any other eligible family members directly into a public program. For example, after a thorough study,[21] Colorado decided not to proceed with premium assistance under its SCHIP program for this reason.

An alternative approach may be possible. States could offer to pay up to their public-program cost toward the family's employer-plan premium and give the family the option of making up the difference out of its own pocket. This option might be attractive to parents who would prefer to have all family members enrolled in the same health plan or who simply prefer their employer plan to the public program. Recent revisions in federal SCHIP regulations now permit such a choice.[22]

Overcoming the Challenges: Successful State Programs

The challenges that states face in implementing successful premium-assistance programs are significant but not insurmountable, as the programs in Iowa, Massachusetts, and Rhode Island demonstrate. For example, Iowa and Massachusetts both have large premium-assistance programs. Iowa has more than 8,000 participants,[23] and Massachusetts has more than 10,000.[24] Rhode Island is steadily adding enrollment to its recently initiated RIte Share program and expects to reach 5,000 enrollees by June 2003 (see Box 1).

Several key factors have contributed to the success of the programs. Each of the three states requires applicants to enroll in employer coverage for which they are eligible, if that coverage is cost effective. Each has

found ways to deal with the difficult issue of wraparound coverage. And each tries to minimize the administrative burden on employers.

Requiring Eligible Applicants to Enroll in Employer Coverage

In order to require applicants to enroll in employer coverage, states must first be able to identify which applicants have employer coverage available to them. Iowa solves this problem by requiring all employed Medicaid applicants to obtain wage- and insurance-verification information from their employers as a condition of eligibility. If an applicant is found eligible, and the employer offers health insurance, the local eligibility office forwards the employer information to the central Health Insurance Premium Payment unit, which follows up to obtain detailed information about the benefits and costs of the employer plan. The cost-effectiveness of "buying in" to the employer plan is then determined by a computerized system. If buying in is found to be cost effective, Medicaid participants are directed to enroll in the employer plan at the next opportunity. Participants pay their share of the premium by payroll deduction, and the state sends them a check for the same amount, on the same schedule.[25]

Addressing Wraparound Coverage

In Iowa, Rhode Island, and Wisconsin, premium-assistance participants continue to receive a traditional Medicaid card, which allows them to access services not covered by their employer plans. Under a federal demonstration waiver,[26] Massachusetts, which offers premium assistance under both Medicaid and SCHIP, uses a different approach. Rather than provide services to supplement employer coverage, Massachusetts requires that to qualify for premium assistance, employer plans must cover a specified list of services, called the Basic Benefit Level.[27]

Minimizing the Administrative Burden

Successful premium-assistance programs minimize the administrative burden on employers, particularly with respect to subsidy administration. Rhode Island had little success with its initial approach, which asked employers to receive subsidy payments from the state and reduce the payroll deduction for premium-assistance-eligible workers. In the first year of operation, only about 275 individuals were enrolled in premium assistance. After the state decided, in early 2002, to make subsidy payments directly to families, rather than through their employers, 1,700 individuals were enrolled within six months.[28]

Implications of New Federal Waiver Opportunities for Premium Assistance

States may find it easier to adopt and implement effective policies with new waiver guidance from the federal government. In August 2001, the federal government issued the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, which offered formal guidance about a potential new use of demonstration waivers.[29] Table 2 highlights the ways in which HIFA waivers could ease federal requirements that often make implementing premium assistance unnecessarily difficult. Primarily, these waivers would allow greater flexibility in how benefit standards and cost-sharing limitations are applied to employer plans. Using HIFA, for example, a state could design consistent policies across Medicaid and SCHIP income boundaries while creating more elegant subsidy and other policies that better fit the world of employment-based family coverage.

Conclusion

As the examples discussed in this article suggest, premium assistance toward employer-based family coverage could provide a sensible coverage source for many low-income children, while helping assure that SCHIP coverage complements the employer coverage system for most non-poor children. Nonetheless, this approach presents challenges. Early program experiences indicate that while obstacles can be overcome, incremental improvements to highly fragmented and administratively burdensome approaches are unlikely to cover many more children.

Alternatively, creative and responsible use of the kind of flexibility offered by the HIFA waiver initiative has the potential to work as a cost-effective coverage vehicle for many children and their families. While balancing competing policy objectives will be difficult, in an environment of budgetary constraints, increased use of premium assistance can constructively link public and employer benefits and help maximize the number of children covered by health insurance.

ENDNOTES

1. Both SCHIP and Medicaid are authorized to use public funds to help eligible families pay premiums for employer-based coverage, rather than provide coverage directly. Usually, premium-assistance recipients pay for their employer coverage by payroll deduction, just as other workers do, and receive a separate payment from the state program to cover their outlay.
2. In 2002, the average employer paid 73% of the cost of full family coverage, which averaged $7,954 per year, or about $663 per month. Workers paid, on average, $174 per month for full family coverage. Kaiser Family Foundation and Health Research and Educational Trust. *Employer health benefits: 2002 annual survey.* Menlo Park, CA: Henry J. Kaiser Family Foundation, and Chicago, IL: Health Research and Educational Trust, 2002.
3. The state pays health plans $450 per month for an average family enrolled in RIte Care. Under the RIte Share premium-assistance program, the state's average monthly contribution to a family's employer-sponsored coverage is $272. Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RIte Share program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.
4. The underlying argument is that parents will know how to get care for their children if they are familiar with the health plan, because they use it themselves. See Hanson, K. Is insurance for children enough? The link between parents' and children's health care revisited. *Inquiry* (Fall 1998) 35:294–302.
5. Dubay, L., and Kenney, G. *Covering parents through Medicaid and SCHIP: Potential benefits to low-income parents and children.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2001.
6. Child enrollment in RIte Care grew from 48,884 in December 1995 to 52,046 in December 1998 to 76,379 in December 2001. Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RIte Share program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.
7. See also Kaiser Commission on Medicaid and the Uninsured. *Health insurance coverage in America: 2002 data update.* Washington, DC: KCMU, February 2002, Table 2 (based on Urban Institute analysis of data from the March 2001 Current Population Survey).
8. Kronick, R., and Gilmer, T. Insuring low-income adults: Does public coverage crowd out private? *Health Affairs* (January/February 2002) 21(1):225–239. Marquis, M.S., and Long, S.H. Public insurance expansions and crowd-out of private coverage. To be published in *Medical Care*, 2003. In contrast, most studies of Medicaid's expansion of coverage to children up to 133% of the federal poverty level and pregnant women to 185% of the federal poverty level during the late 1980s and early 1990s found only relatively modest crowd-out of employer coverage. For a review of this work, see Dubay, L. *Expansion in public health insurance and crowd out: What the evidence says.* Menlo Park, CA: Henry J. Kaiser Family Foundation, October 1999.
9. Rhode Island Department of Human Services. Update: RIte Care, member cost sharing, RIte Share. Providence, RI: Hearing of the Joint Committee on Health Care Oversight, April 29, 2002. Slide presentation. Based on Medicaid Research and Evaluation Project; RIte Share Evaluation Studies. U.S. Bureau of the Census, Current Population Surveys 1994–2000 (September estimates).
10. Rowland, C. Officials rethinking RIte Care's mission. *Providence Journal.* May 21, 2000, at p. A-01.
11. As of June 2002, 12 states were operating premium-assistance programs. Programs in 4 states (Iowa, Missouri, Pennsylvania, and Texas) were available only to Medicaid recipients. Virginia operated separate programs for Medicaid and SCHIP recipients. Maryland offered premium assistance only under its separate SCHIP program for children between 200% and 300% of the federal poverty level. Illinois offered premium assistance to children, without federal matching funds, as an alternative to enrollment in its SCHIP "KidCare" program. Wisconsin offered premium assistance only to family groups in the SCHIP income range. And 3 states (Massachusetts, New Jersey, and Rhode Island) offered premium assistance to families and children as part of broader demonstration projects encompassing both Medicaid and SCHIP. Finally, using state funds only, Oregon offered premium assistance to any income-eligible adult or child. [State Coverage Initiatives. *State Coverage Matrix.* Updated June 2002. Accessed August 22, 2002. Available online at http://www.statecoverage.net/matrix.htm. Also state Web sites for Illinois (http://www.kidcareillinois.com/html/enrollment.htm) and Oregon (http://www.ipgb.state.or.us/Docs/fhiaphome.htm) and author's personal communication with Kelly Carter, Manager of KidCare Customer Service, Illinois Department of Public Aid, June 6, 2001. For more in-depth information about many of these state programs, see *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage.* Washington, DC: Institute for Health Policy Solutions, May 18, 2001.] Most other states operate limited premium-assistance programs only for Medicaid recipients with significant health problems, but these programs serve very few recipients, and little is known about them.
12. Sexton, J. *Overview of the Iowa Health Insurance Premium Payment (HIPP) program.* Washington, DC: Institute for Health Policy Solutions, February 4, 2000. Available online at http://www.ihps.org.
13. Despite the prevalence of managed care in Medicaid, most state Medicaid programs can still pay claims submitted directly by providers on a traditional fee-for-service basis. Separate (and newer) SCHIP programs, by contrast, often do not have direct claims-payment capability. Instead, these programs contract with private health plans to enroll SCHIP eligibles on a capitated basis.
14. Because of the expensive wraparound coverage, Mississippi never implemented premium assistance under its separate SCHIP program after receiving federal approval to do so. State Coverage Initiatives. *State Coverage Matrix: Mississippi.* Updated June 2002. Accessed August 22, 2002. Available online at http://www.statecoverage.net/ms-employer.htm.
15. Nothing prohibits individual SCHIP programs from contracting with their state's Medicaid program or fiscal agent to provide wraparound coverage for SCHIP premium-assistance recipients. To avoid the need for major system modifications that could make such a proposition too expensive, the state would probably have to give SCHIP premium-assistance recipients access to the full Medicaid benefit package and cost-sharing protections. The equity of such an arrangement might be questioned, because it would give premium-assistance recipients greater benefits than other SCHIP participants; but the Medicaid experience with

wraparound coverage suggests that this concern is more theoretical than practical. Political opposition to such an approach might be hard to overcome, however, because opposition to expansion of the Medicaid program was one of the major reasons behind states choosing to implement separate SCHIP programs.

16. Chang, D. Maryland Children's Health Premium Program: Premium assistance challenges and opportunities. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.

17. Institute for Health Policy Solutions. Unpublished analysis of the 1996 Medical Expenditure Panel Survey (full-year panel).

18. Neuschler, E., and Curtis, R. *Individual workers' wage levels, total family income relative to poverty, and prevalence of employer coverage*. Washington, DC: Institute for Health Policy Solutions, August 2001, Figure 3.

19. The risk of crowd-out would be great if virtually free public coverage were made available to applicants with low family incomes but relatively high individual wages. Higher-wage workers are very likely to already have employer coverage. For this reason, taking individual parents' wage levels into account, not just total family income, could be a powerful tool in designing policies that would effectively expand coverage of the uninsured rather than simply substitute public coverage for existing employment-based coverage. In particular, requiring a premium contribution (for public-program coverage of an adult) that increased with wage level would make people less likely to drop employer coverage or switch jobs to qualify for publicly financed coverage. See Neuschler, E., and Curtis, R. *Expanding healthy families to cover parents: Issues and analyses related to employer coverage*. Washington, DC: Institute for Health Policy Solutions, January 2001.

20. The cost-effectiveness of premium assistance is determined by comparing the cost to enroll all family members in the employer plan with the cost to enroll eligible family members in the public program. Under an employer plan, covering only children is not possible. Parents usually must pay for full family coverage in order to cover their children. (Some plans allow workers to cover their children without covering their spouses, for a lower premium, but workers must always be covered.) The public-program cost, on the other hand, varies directly with the number of eligible family members (and, usually, with their ages and genders). If only the children are eligible, the public-program cost will be lower than if all family members are eligible, and, therefore, only employer plans with lower contribution requirements for family coverage will qualify for premium assistance.

21. Schulte, S., Yondorf, B., Howell, L., and Leif and Associates. *Final report of the Child Health Plan Plus employer buy-in feasibility study.* Denver, CO: Rose Community Foundation, December 2001.

22. The revised SCHIP regulations at 45 CFR 457.560 indicate that states could treat premiums for family coverage as they do coverage of other family members, rather than counting them against the out-of-pocket expenditure limit for children's coverage. Department of Health and Human Services, Health Care Financing Administration. State Child Health; Revisions to the Regulations Implementing the State Children's Health Insurance Program; Final Rule. *Federal Register* (June 25, 2001), vol. 66, no. 122, pp. 33810–24. See especially p. 33815. See also Federal Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration). *Health Insurance Flexibility and Accountability Demonstration Initiative*. August 2001. Available online at http://www.hcfa.gov/medicaid/hifa/default.htm.

23. See note 12. Total HIPP enrollment includes about 5,500 Medicaid eligibles and about 3,000 ineligible family members.

24. Waldman, B. Coverage goals and implementation experience. In *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage*. Washington, DC: Institute for Health Policy Solutions, May 18, 2001. Total premium-assistance enrollment includes about 6,000 program eligibles and more than 4,000 ineligible family members.

25. See note 12. As noted, however, Iowa has not implemented premium assistance under its separate SCHIP program because that program has no mechanism to fill in employer-plan cost sharing or to pay for SCHIP services not covered by the employer plan.

26. This waiver dates from the mid-1990s and was not issued pursuant to the new Health Insurance Flexibility and Accountability Demonstration Initiative.

27. In early 2002, Massachusetts received federal approval to use "secretary-approved coverage" as the "benchmark" for its premium-assistance program, rather than the "largest commercial HMO" benchmark used for its regular SCHIP program. This approval was granted on the basis that the narrower list of services had previously been approved for use in premium assistance under the state's Medicaid demonstration waiver program. Prior to this approval, children could receive premium assistance if their employer plan equaled or exceeded the Basic Benefit Level. But if their employer plan met the SCHIP benchmark (which very few employer plans do), the state was allowed to claim the higher federal SCHIP matching rate. Massachusetts Division of Medical Assistance. Personal communication with Colleen Murphy, assistant general counsel, May 15, 2002.

28. See note 6, Leddy.

29. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative*. August 6, 2001. Available online at http://www.cms.hhs.gov/hifa/hifagde.htm.